

## 2010 BCBS of WNY Benefit Comparison for the Greater Olean Chamber of Commerce

Services	BCBS of Western New York POS 7100 HSA compatible	Community Blue 206 HMO	Community Blue 206 HMO Plus Pick your copays (\$10/\$40 or \$20/\$30)
<b>Deductible</b>	<b>\$1,500 Single/\$3,000 Family</b>	<b>N/A</b>	<b>N/A</b>
<b>Coinsurance</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Out of Pocket Max.</b>	<b>\$5,000 Single/\$10,000 Family</b>	<b>N/A</b>	<b>N/A</b>
<b>Referrals</b>	Not Required	Not Required	Not Required
<b>Office Visits</b>	PCP: \$0 copay after deductible Specialist: \$0 copay after deductible	\$25 PCP \$25 Specialist	\$10 or \$20 PCP \$40 or \$30 Specialist
<b>GYN Routine Exams</b>	Covered in Full	\$25 Copay	\$10 or \$20 Copay
<b>Adult Physicals</b>	Covered in Full	\$25 Copay	\$10 or \$20 Copay
<b>Well Child Visits</b>	Covered in Full	Covered in full to age 19	Covered in full to age 19
<b>Sick Child Visits</b>	\$0 copay after deductible	\$25 Copay	\$10 or \$20 Copay
<b>X-rays</b>	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
<b>Mammograms</b>	Covered in Full	Covered in Full	Covered in Full
<b>Laboratory</b>	\$0 copay after deductible	Covered in Full	Covered in Full
<b>Hospital Inpatient</b>	\$0 copay after deductible	\$250 Copay	\$250 Copay
<b>Maternity Care</b>	Prenatal: \$0 copay after deductible Delivery: \$0 copay after deductible Hospital: \$0 copay after deductible	Prenatal: CIF after initial visit Copay Delivery: \$0 Copay Hospital: \$0 Copay	Prenatal: CIF after initial visit Copay Delivery: \$0 Copay Hospital: \$0 Copay
<b>Mental Health</b>			
<b>Inpatient: 30 day max</b>	\$0 copay after deductible	\$250 Copay	\$250 Copay
<b>Outpatient: 20 visits</b>	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
<b>Outpatient Surgery</b>	\$0 copay after deductible	\$150 Copay	\$150 Copay
<b>Emergency Room</b>	\$0 copay after deductible	\$100 Copay	\$100 Copay
<b>Routine Eye Exams</b>	Covered in Full	\$25 Copay	\$30 Copay
<b>Eye Wear</b>	Discounts available	Discounts available	Discounts available
<b>Acupuncture</b>	Not Covered	Not Covered	Not Covered
<b>Chiropractic</b>	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
<b>Durable Medical Equipment</b>	\$0 copay after deductible (\$1,000 max)	50% Copay (\$1,000 annual max)	50% Copay (\$1,000 annual max)
<b>External Prosthetics</b>	\$0 copay after deductible (\$1,000 max)	50% Copay (\$1,000 annual max)	50% Copay (\$1,000 annual max)
<b>Diabetic Supplies/ Insulin/Oral Agents</b>	\$0 copay after deductible	\$25 Copay	\$10 or \$20 Copay
<b>Prescription Drug</b>	<u>Copay per 30 day supply (after deductible)</u>	<u>Copay per 30 day supply</u>	<u>Copay per 30 day supply</u>
<b>Mail Order Mandatory for Maintenance</b>	Tier 1/\$15 Copay Tier 2/\$50 Copay Tier 3/50% Copay Mail Order: 2.5 copays for 90 day supply	Tier 1/\$15 Tier 2/\$50 Tier 3/50% Mail order: 2.5 copays for 90 day supply	Tier 1/\$15 Tier 2/\$50 Tier 3/50% Mail order: 2.5 copays for 90 day supply
<b>Out of Network Benefit</b>	Deductible: \$1,500 Single/\$3000 Family Coinsurance: 30% OOP: \$10,000/\$20,000	Deductible: \$1,000 Single/\$2,000 Family 30% Coinsurance OOP Max. \$5000 Single/\$10,000 Family	Deductible: \$1,000 Single/\$2,000 Family 30% Coinsurance OOP Max. \$5000 Single/\$10,000 Family
<b>Dependent Coverage</b>	Age 19 (Students to 25)	Age 19 (Students to 25)	Age 19 (Students to 25)
<b>Rates</b>			
<b>Single</b>	<b>\$275.27</b>	<b>\$452.24</b>	<b>\$452.24</b>
<b>Family</b>	<b>\$746.77</b>	<b>\$1,238.91</b>	<b>\$1,238.91</b>